**Social History Questionnaire**

*All questions contained in this questionnaire are strictly confidential and will become part of your medical record.*

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| Basic Information |
| Patient Name: | Date of Birth: |

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| Tobacco Products:Do you have a history of smoking or currently smoking: □YES □NOType: □Cigarette □Cigar □PipeStart Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Amount of Cigarettes:□ Less that 1 cigarette/day□ Light (1-9 cigs/day)□ Moderate (10-19 cigs/day)□ Heavy (20-39 cigs/day)□ Very Heavy (40+ Cigs/day)Interested in quitting smoking: □YES □NOStop Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Smokeless:Do you have a history with smokeless tobacco or currently us: □YES □NOType: □Chew □Snuff □PowderStart Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Interested in quitting smokeless:□YES □NOStop Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Alcohol Use:□ Non-Drinker□ Current Alcohol userType: □Beer □Hard Liquor □WineDrinks/Day on typical drinking day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_High risk alcohol use: □YES □NOBinge Drinker: □YES □NOPast heavy use: □YES □NOAlcohol Treatment Program: □YES □NOComments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Caffeine Use:□ NO Caffeine use□ Uses CaffeineType: □Coffee □Tea □Soda □Energy Drinks □Caffeine SupplementsTotal Amount:□ Excessive (equivalent to 10+ 8oz Coffee per day)□ Heavy (equivalent to 4-9 8oz Coffee per day)□ Moderate (equivalent to 1-3 8oz Coffee per day)□ Minimal (equivalent to <1 8oz Coffee per day)Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Diet Nutrition:Difficulty Chewing: □YES □NODifficulty Swallowing: □YES □NOHistory of Eating Disorder: □YES □NOFinancial Issues affecting the ability to buy needed food: □YES □NOSpecial Diet:□ Diabetic □ Gluten Free □ Low Fat□ Low Sodium □ Renal □ Vegan□ Vegetarian □ Weight Reduction □ OtherComments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Environment:Do you live alone: □YES □NO |